The Commonwealth of Massachusetts
State Board of Retirement
One Ashburton Place, Boston, MA 02108-1607

Timothy P. Cahill
Treasurer and Receiver General
Chairman

ROOM 1219
(617) 367-7770
1-800-392-6014

NEW MEMBER ENROLLMENT FORM

SECTION A: To be filled out by employee.

1. (Please print or type, except for signature)

Name……	Former Name:……..	SSN:……..
Street Address…… City……., State……, Zip Code……..	D.O.B:……/……/…….. Phone #……	Sex:……..
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced	Spouse D.O.B:……/……/……	Number of Children:….....
Are you a Veteran? ☐ Yes ☐ No	Position:…….. Start Date:……	
Dates of Military Service:…… A COPY OF A MILITARY DISCHARGE MAY BE REQUESTED	Agency or Department…….. Agency Phone #……..	

The retirement law establishes specific periods of active service, which may qualify you for certain Veteran benefits.

2. Past membership history with any other contributory retirement system in Massachusetts.

RETIREMENT SYSTEM	FROM	TO	WAS REFUND TAKEN	
			☐ YES	☐ NO
			☐ YES	☐ NO
			☐ YES	☐ NO
			☐ YES	☐ NO

3.

Are you currently or have you ever received a retirement allowance from another public retirement system? ☐ Yes ☐ No

4. **Statement and Signature By Member**

I certify the above information to be true and correct to the best of my knowledge and hereby accept membership in the Massachusetts State Retirement System. This statement is signed under penalties of perjury.

Date:…….. Signature……

5. **TO BE FILLED OUT BY OUT THE AGENCY.**

POSITION		DEDUCTION	SERVICE STATUS
		☐ 5%	☐ Full-Time
		☐ 7%	☐ Part-Time……%
Start Date:……		☐ 8%	☐ Temp/Sub:
Start Date:……		☐ 9%	
STATE POLICE Start Date:……		☐ 12%	
Date of First Deduction:……..	☐ New ☐ Transfer	☐ 30 Plus	☐ Other

Agency Name and Payroll Number:……...

Authorized Signature:…….

BENEFICIARY INFORMATION

Beneficiary or beneficiaries nominated will receive in the proportion designated any sum due at your death. The right to change any nominated beneficiary is reserved by the member.

A BENEFICIARY BLANK WITH CORRECTIONS OR ERASURES IS NOT ACCEPTABLE

GIVE COMPLETE NAME AND ADDRESS OF EACH BENEFICIARY	BENEFICIARY D.O.B.	RELATIONSHIP to MEMBER	PROPORTION of BENEFIT*
Name……... Address……...	……	……	……
Name……... Address……...	……	……	……
Name……... Address……...	……	……	……
Name……... Address……...	……	……	……
Name……... Address……...	……	……	……

Date:……. Signature:……

Signature of Witness:……

Must Total 100% -- If Contingent Please Specify

(A CHANGE IF BENEFICIARY FORM must be used if you wish to change your designated beneficiary/beneficiaries. You may obtain this form from your payroll department or from the board of retirement)